Creating a 5-Star Health Insurer

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Peppers&Rogers Group

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Executive Summary

Innovation in the healthcare industry typically refers to new treatment strategies or breakthrough drugs. But for some health insurance companies, innovation can mean something different. Innovating around the customer experience can have an immediate impact on consumers as well as the balance sheet.

As part of the Affordable Care Act, the federal government now rates Medicare Advantage and Part D prescription drug programs on a five-star scale, with five stars representing the best performance. They are measured by how well they deliver across customer-related dimensions such as staying healthy, managing chronic care, member experience, complaints and performance, and customer service. Plans with high ratings receive bonus payouts totalling hundreds of millions of dollars.

For insurers that want to achieve top ratings, a clear focus on overall plan quality is the right approach. Any improvements need to be holistic and considered from the point of view of the entire member lifecycle, not just focused on improving the individual measures that comprise the inputs to the star ratings. It is the perfect time to innovate around customers.

Highlights:

- For 2012, the total bonus payment is projected to be nearly $3.1 billion, split among the highest-rated plans.
- Currently less than 1 percent of plans achieve five-star ratings, and about 44 percent receive less than three stars.
- Outcome-based measures that tie to the improvement of health and care are weighted highest.
- To achieve the highest ratings possible, payers must create customized interactions that will meet each member's needs at multiple points in the member experience.

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Health Plans Go Under Scrutiny

Each year, the Centers for Medicare and Medicaid Services (CMS)—the federal agency that oversees Medicare—rates Medicare Advantage and Part D prescription drug programs on a five-star scale, based on how well they performed in the prior year, with five stars representing the best performance. Plans with high ratings receive bonus payouts of up to hundreds of millions of dollars. For 2012, the total bonus payment is projected to be nearly $3.1 billion, with a few companies taking the lion's share—UnitedHealthcare is projected to receive $547 million and Kaiser Permanente is projected to receive $380 million, according to the Kaiser Foundation.

The idea behind this bonus payment system is two-fold. First, it rewards plans that do well by awarding them a higher bonus payment. Second, it brings down overall Medicare program costs by cutting down on payments made to plans in excess of projected spending. For consumers, the system provides an easy way to shop for and compare plans during enrollment periods. This new program began in 2011 and is scheduled to continue until at least 2014. The first payouts were delivered in 2012.

Plans with the best performance can receive bonus payouts of up to hundreds of millions of dollars.

What does a five-star health plan look like?

Medicare plans are measured by how well they deliver across five customer-related dimensions: staying healthy, managing chronic care, member experience, complaints and performance, and customer service. For example, the complaints and performance dimension measures the number of complaints submitted for every thousand members and the problems that Medicare found in members' access to service and in the plan's performance. Similarly, Part D programs are rated on drug plan customer service, member complaints and performance, member experience, and patient safety and pricing accuracy. For example, measures under the drug plan customer service dimension cover the time spent on hold when a pharmacist calls the health plan and the availability of foreign language options in the contact center (see Figure 1). A number of stakeholders provide feedback and data to inform the CMS rating, including consumers, doctors and hospitals, pharmacists, and regulators.

FIGURE 1: How Health Plans Are Rated

The CMS rating system is based on how well a health insurance plan delivers on a number of customer-related attributes.

Medicare Advantage
Quality Rating Attributes

Staying Healthy	Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy
Managing Chronic Care	Includes how often members with different conditions got certain tests and treatments that help them manage their condition
Member Experience	Includes rating of member satisfaction with the plan
Complaints and Performance	Includes how often members filed a complaint against the plan
Customer Service	Includes how well the plan handles appeals from members

Medicare Part D
Quality Rating Attributes

Drug Plan Customer Service	Includes responsiveness of support and timeliness and fairness of the appeals process
Drug Plan Complaints and Performance	Includes accuracy and safety of prescription, along with adherence to guidelines for certain conditions
Member Experience with Drug Plan	Includes ratings of member satisfaction with the plan and ability to get help
Drug Plan Pricing and Patient Safety	Includes drug pricing, medication adherence and safety of prescriptions

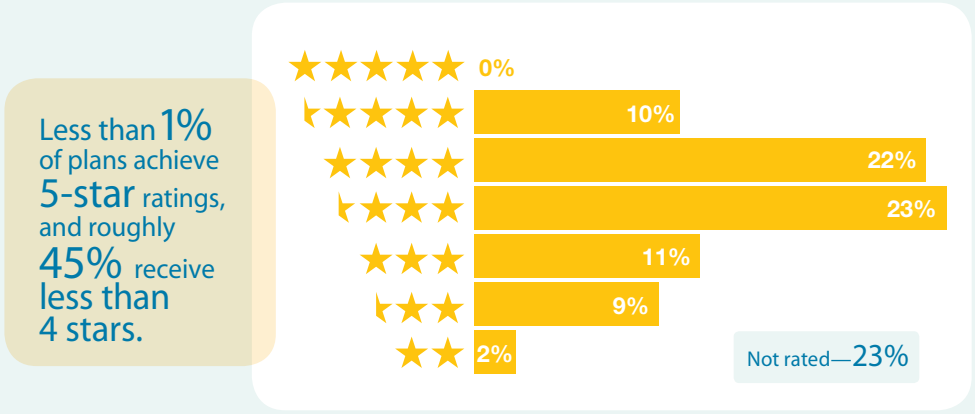
Some measures are weighted more heavily than others. CMS broadly groups measures into five categories, including process-, experience-, access- and outcome-based measurements. Outcome-based measures that tie to the improvement of health and care are weighted highest while process-based measures are weighted the lowest.

Reach for the stars

The goal of the rating system and bonus structure is to ultimately create better health outcomes for plan members. Customer satisfaction with the health insurance industry overall is low. Consumers are used to a higher quality of service each day from vendors in other industries and seek that same experience from their health plan as well. Payers looking at only the dollar bonus amounts will miss out on the bigger opportunity to create a better health plan, which will create satisfied members and retain them over the long term. This leaves much opportunity for improvement among health plans.

FIGURE 2: Distribution of Medicare Advantage Star Ratings, 2012-2013

When it comes to enhancements in efficiencies and the member experience, there is much opportunity for improvement among health plans. Very few receive high rankings, as shown in the accompanying chart.



Source: Centers for Medicare and Medicaid Services

However, some health plans have begun to take notice and have made changes in order to obtain a higher star rating. Of the 419 Medicare Advantage plans rated in both 2012 and 2013, 28 percent showed improvement over the previous year. Similarly, of 59 Part D plans rated in 2012 and 2013, 49 percent improved their ratings in 2013.

Insurers looking to improve must place the member at the top of their organizational priority list; in other words, they must create a customer-centric organization. Many of the rankings are based on how well elements of the healthcare system work together. This requires a transformation in the way payers treat their members by rethinking organizational design, customer experience strategy, and customer trust, among many other actions, to create a richer member experience. And CMS will periodically update its list of measures, making this customer-centric transformation a journey, not a one-time process.

Customers today have increasing choice when it comes to their health plans and will exercise those choices, especially when there is a rating attached to a plan. For health insurers, this means that paying attention to star ratings and creating the right conditions for a higher star performance will become even more important going forward.

The Way Ahead Requires a Holistic Approach

For insurers that want to stay on top of the star ratings program, a clear focus on higher overall plan quality is the right approach. Any improvements need to be holistic and considered from the point of view of the entire member lifecycle, not just focused on improving the individual measures that comprise the inputs to the star ratings. Ratings can drop for many reasons and while some of these are relatively easy to fix, such as getting members to have an annual flu vaccine, others might prove to be more of a challenge, such as patient adherence to prescription medication guidelines.

Consider the evaluation of a member's overall rating of a health plan. An overall rating is the sum of many factors, largely driven by that member's experience with the health plan across multiple interactions. At each of these interactions, a member's expectations on the desired experience can vary widely from member to member.

A member who has just turned 65, is still working, and lives at home has a different set of needs and expectations than an older member who is 80 and lives in a retirement home. A member with a chronic illness will require more attention and handholding than a member who comes in for screenings and basic checkups.

In order to create a satisfied member who will give a high overall rating for the health plan, the payer must create customized interactions that will meet each member's needs at multiple points in the member experience. To do this, each member's needs, behaviors, and value to the health plan must be carefully analyzed from the point of view of the member lifecycle. A holistic approach to improving ratings can thus ensure that the member's needs are met during each interaction and will leave the member satisfied and less likely to switch plans the next time enrollment period comes around (see sidebar on page 6).

Any improvements need to be holistic and considered from the point of view of the entire member lifecycle, not just focused on improving the individual measures that comprise the inputs to the star ratings.

Another benefit of a holistic approach is that CMS updates the inputs to its star ratings annually. The agency has structured the star ratings strategy to be consistent with its three-part aim: better care, healthier people and communities, and lower-cost care through improvement. Any future updates to the measures will incorporate this strategy.

Therefore, an approach to create the ideal experience must look at all aspects of the member lifecycle; otherwise the result will be a piecemeal approach that will result in lopsided or short-term gains to the ratings.

The Added Benefits of 5 Stars

The benefits of a five-star rating are many and go well beyond just the bonus payments:

- Plans rated five stars can enroll members during additional periods throughout the year, not just during the Open Enrollment period.
- Bonus payments received by the plans must be reinvested back into the plan to improve the plan's features and services. This means that plans that were already of a higher quality will have the resources to offer more benefits to members and raise their standards even higher, making it harder for the other plans to catch up.
- Bonus payments are on the rise. The previous bonus amount was capped at 1.5 percent of the maximum amount Medicare will pay the plan to provide Part A and B benefits. But going forward, as part of the CMS' demonstration, that amount will be raised to 5 percent. That adds up to more than $500 million in potential payouts for each plan.
- CMS provides indirect marketing support when they promote five star plans on their website.
- CMS also actively encourages members to make the switch to a higher rated plan while members search for a plan to join using the Plan Finder tool on the website.
- Starting in 2015, CMS will have the authority to terminate plans that have failed to score at least three stars for three consecutive years.

Moving the Needle Toward 5 Stars with Holistic Action

John is a 68-year-old grandfather who has just been diagnosed with rheumatoid arthritis. He has had joint pain before, but today he learned about his diagnosis. He is confused and shocked. He does not know anyone else with rheumatoid arthritis and does not fully understand the doctor's discussion of his options. How can his healthcare experience be improved?

CMS has a metric that specifically measures the percentage of members who were diagnosed with rheumatoid arthritis and dispensed a prescription for an anti-rheumatic drug. A simple way to improve an insurer's star ratings would involve creating a set of incentives for providers to ensure that every diagnosis is followed up with a prescription for this drug.

However, in order to ensure a better health outcome for John and create a satisfied customer, a more holistic approach is required. John's customer experience and condition are an opportunity to provide a higher level of service. John is about to experience a "moment of truth," a critical point in the customer experience that will decide his level of satisfaction with his insurer. There are a number of ways the insurer can influence John's satisfaction, customer experience, and overall health. For example:

On-boarding: Upon diagnosis, John would receive a special hotline number and be connected to a nurse at his health plan who specializes in this condition. This begins the on-boarding process, which introduces John to the care management process for his condition. The nurse would take the time to talk to him about his options and mail him a checklist of future appointments and screenings that need to be completed, together with an action plan for daily physical activity.

Online: John would then get online on his health plan's portal and visit the micro-site that has been created specifically for his condition. The site, designed with a large font for easy reading, would list detailed short- and long-term projections of treatment costs side-by-side with treatment options. The portal would connect him with fellow health plan members who also have the condition to share support and discuss strategies on how to tackle it.

On-time: A week before his doctor's appointment, an automated IVR would call John or leave him a text reminder, with an option to cancel if he cannot make it.

Steps like these are more complex and require many stakeholders and systems to work together. The payoffs are correspondingly higher — higher customer satisfaction, higher ratings on multiple CMS' metrics — specifically healthcare quality rating, plan rating, better beneficiary access, increased customer tenure — and possibly even healthier outcomes for John. At the end of the day, that is what healthcare is all about.

Conclusion

Consumers rely on ratings and reviews to assist their decision-making in nearly every other industry. So why not healthcare? The ratings bonus program from CMS presents an immediate opportunity for health insurers that operate in the Medicare space to get ahead of the competition and stay there as the healthcare industry evolves. Monetary, relationship, and reputational benefits are all at stake. It is the perfect time to innovate around customers. ■

About the Authors

Marc Ruggiano is a Partner and Healthcare Practice Leader at Peppers & Rogers Group. Marc led the development of Peppers & Rogers Group's Healthcare practice, driving our latest thinking and serving industry leaders in health insurance, pharmaceutical and healthcare delivery. Marc's most recent work has focused on shepherding health insurance payers through the dramatic changes facing the industry in light of government reform, technology innovation and an increasingly empowered consumer. Marc holds an MBA from the Darden School at the University of Virginia where he was a Raven Award winner, and a B.S. in Computer Science from the United States Naval Academy.

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About Peppers & Rogers Group Healthcare Practice

Peppers & Rogers Group's Healthcare Practice applies its strategy expertise and market experience to the unique dynamics of the healthcare industry, serving leading Health Insurance, Pharmaceutical and Health Delivery companies. We offer functional expertise in patient/consumer profiling, stakeholder analytics and segmentation, key influencer strategy, new business development effectiveness, organizational alignment, stakeholder interaction strategies, service line commercialization, case management strategy, automated patient management design, portfolio optimization, privacy compliance, and change management.

About TeleTech Holdings

Peppers & Rogers Group is a division of TeleTech Holdings, a global leader in Customer Experience and outsourced customer management. For more than 30 years, TeleTech has been committed to helping its clients build emotionally engaged and profitable relationships with their customers. The firm is built on the understanding that to serve customers and differentiate their brand, clients need a holistic strategy that begins and ends with customer insight and expectations. To respond to this revolution in customer expectations, TeleTech has brought together innovative consulting, technology, and process improvement capabilities.

It is within this context that Peppers & Rogers Group, the leading management consulting firm in customer strategy, was acquired more than two years ago. With the addition of Peppers & Rogers Group, TeleTech is now able to offer the integrated set of strategic, analytical, and implementation capabilities required to deliver the optimal customer experiences that drive real change for our clients and their customers.